STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Non-compliance Revisit and Complaint Investigation #KS65320, #KS65512, #KS66305 and #KS65972.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 49 residents. The sample included 9 residents. Based on observation, record review and interview the facility failed to provide an ongoing activity program for 4 (#4001, #4006, #4007, #4008) of the 4 residents reviewed for activities. Findings included: - The Physician Order Sheet (POS) dated 5/30/13 listed the following diagnoses for resident #4001: agitation (extreme emotional disturbance) and dementia (progressive mental disorder characterized by failing memory, confusion). The admission Minimum Data Set 3.0 with the Assessment Reference Date (ARD) 5/10/13 noted the resident had short and long term memory problems and was moderately impaired with decision-making skills. It was important for him/her to listen to music, do things in groups of	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

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F 248	Continued From page 1	F 248		

people, go outside when the weather was nice and was somewhat important for him/her to participate in religious events, do favorite activities, keep up with the news, and be around pets or animals. The resident required staff supervision to being independent with all Activities of Daily Living (ADL) except needed extensive assistance with personal hygiene.

The Care Area Assessment (CAA) for Cognition dated 5/14/13 noted the resident was not sure that he/she was in a nursing home, was unable to report the season or the year, and had difficulty responding to questions as he/she spoke of things irrelevant to the questions asked by staff.

The ADL CAA dated 5/14/13 listed the resident was admitted from another facility. He/she was mostly independent with mobility and transfers, but required some occasional physical assistance.

Care plan dated 5/21/13 for impaired cognition listed interventions to maintain a calm and relaxed manner, speak slowly and distinctly, introduce self frequently, provide visual cues, use simple direct request, reorientation/validation as needed, provide consistency in the daily routine, face the resident when speaking and encourage use of visual cues in room.

The clinical record lacked a care plan for activities.

Activity Interest Assessment dated 5/13/13 listed the resident was alert to name and had short and long term memory problems. He/she enjoyed games, music, exercise, reading, food, pets ,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 2	F 248		

gardening, and watching TV. News and religion were noted as past interests. He/she interacted well with spouse. Staff to encourage group activities and assist as the resident was able.

The Activity Progress note dated 5/20/13 (untimed) said the resident was alert and oriented to name, and enjoyed listening to music and watching TV.

Review of the Activity Participation Record for May 2013 listed the resident watched TV and listened to music several days a month and was an active participant 1 to 3 days in the month in some other facility offered activities.

Observation on 6/4/13 at 11:50 A.M. revealed the resident laid in bed, watching TV.

On 6/5/13 at 7:50 A.M. there was a crossword puzzle book and Bible laying on the bedside table. The resident said he/she did not read the Bible, they had them in all the rooms. He/she said he/she enjoyed doing crossword puzzles.

Observation on 6/5/13 at 10:30 A.M. revealed the resident attended the religious events activity.

Observation revealed residents attended the Bingo activity on 6/5/13 at 3:00 P.M. but this resident remained in his/her room, door closed, room dark, TV on, and eyes closed. Conversation with the resident at 3:30 P.M., revealed he/she enjoyed Bingo but he/she did not remember anyone asking him/her to go to Bingo today.

On 6/5/13 at 11:20 A.M. interview with consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 248	Continued From page 3	F 248		

HH said the facility would start doing activity care plans on everyone and not just those that the MDS triggered. He/she said the facility would make the care plans individualized to reflect residents' likes and dislikes.

An interview on 6/5/13 at 1:45 P.M. with direct care staff Q said the resident on the day shift consisted of going to Bingo or going to the unit and visiting with his/her spouse. He/she said otherwise the resident stayed in his/her room and watched TV or napped.

Interview on 6/5/13 at 2:40 P.M. an interview with administrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the activity program and the activity calendar. Administrative staff C said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then did the care plan for each resident. He/she said he/she did not use the Activity Interest Assessment to figure out the residents likes and dislikes. He/she acknowledged there was not an activity care plan for this resident. .

An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident should have an individualized care plan for activities.

An interview on 6/5/13 at 4:45 P.M. with direct care staff R said the resident occasionally visited with his/her spouse in the afternoon but usually stayed in his/her room and watched TV in the evening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 4 The facility provided policy for Participation in Activities with revision date of 9/1/11 said residents had the right to attend and participate in activities of their choice. The Director of Therapeutic Recreational Services would maintain a daily record of resident activity involvement. The facility failed to provide an ongoing individualized activity program in accordance to his/her interests for this cognitively impaired, newly admitted resident. - The Physician Order Sheet (POS) dated 4/29/13 listed the following diagnoses for resident #4006: dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind). The annual Minimum Data Set (MDS) 3.0 with the Assessment Reference Date (ARD) of 3/15/13 listed the resident had short and long term memory problems and was severely impaired with decision making skills. The resident liked listening to music and doing things in groups. He/she needed extensive assistance with bed mobility, transfers, dressing, eating, personal hygiene, and limited assistance with walking on the unit and in the corridor.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 5	F 248		

The Activity Care Area Assessment (CAA) dated 3/18/13 noted the resident triggered the CAA because he/she did little in activities. He/she attended activities but was mostly a passive observer.

The care plan for activities dated 6/2/13 noted the resident needed verbal cueing to participate. Interventions included the resident to attend activities on and off the unit.

The Activity Interest Assessment dated 3/15/13 noted the resident was alert with short and long term memory loss, was non-verbal, liked games, music, exercise, pets and TV. He/she needed encouragement to attend activities and enjoyed sitting in the day room, watching TV.

Review of Activity Progress notes dated 3/15/13 said the resident enjoyed sitting in the dayroom participating in music therapy, pet visits, and some exercise. He/she enjoyed independent activities such as watching TV and observing people around him/her.

Review of the monthly Activity Participation Record dated February 2013, March 2013, April 2013, May 2013 and June 2013 revealed the resident was an active participant almost daily with music, watching TV, sensory stimulation, exercise and current events. In May 2013 the resident was a passive participant with music and watching TV. In June 2013 staff recorded the resident was an active participant in 1 to 1 activities, pet visits and watching TV.

Observation on 6/4/13 at 12:35 P.M. revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 6	F 248		

resident sat on the couch in the day room with his/her head down and eyes open. The TV was on but muted while a compact disc (CD) played blue grass music.

An observation on 6/4/13 at 2:10 P.M. revealed the staff assisted the resident to his/her her room, and laid him/her down for a nap. At 2:35 P.M. volunteers and 3 dogs came in the dayroom for pet therapy, the resident remained in bed during this time.

An observation on 6/5/13 at 10:15 A.M. revealed the resident sat on the couch in the dayroom, had his/her head down, eyes closed and rested quietly. Music on in the day room, TV on and muted.

An interview on 6/4/13 at 3:35 P.M. with direct care staff S said the resident would join in activities sometimes but usually watched. He/she seemed to enjoy music and ball toss.

An interview on 6/5/13 at 1:55 P.M. with direct care staff T said the resident occasionally participated in ball toss but not too often. He/she said the resident liked music but did not like staff reading to him/her and did not like to watch TV. Staff said the TV was on mute and the music going so the residents had both visual and auditory stimulation. He/she said pet therapy must be later in the day because he/she never saw pets on the unit during the day shift. He/she said the resident laid down every afternoon for a nap.

An interview on 6/5/13 at 2:03 P.M. with licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 7	F 248		

nursing staff J said there was one game the resident would occasionally play with him/her on a 1 to 1 or would sometimes participate in group activities with staff assistance.

An interview on 6/5/13 at 2:15 P.M. with licensed nursing staff J said on the secured unit the staff were responsible for doing activities with the residents. He/she said what activities they did daily on the unit depended on what was on the activity calendar. We then mark whether the resident was an active or passive participant on their individual participation record. He/she said we did not use the Activity Intake Assessment or the resident's activity care plan for planning the residents' daily activities.

0n 6/5/13 at 2:40 P.M. an interview with adminstrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the activity program and the activity calendar. He/she said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then did the care plan for each resident. He/she said he/she did not use the Activity Interest Assessment to figure out the residents' likes and dislikes. He/she said the staff who work on the secured unit did all the activities for the residents residing on the unit. He/she said he/she expected the staff or anyone doing activities to refer to the care plan and gauge the activity program from the care plan.

An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident should have an individualized care plan for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 8	F 248		

activities. He/she acknowledged that when staff used only the monthly activity calendar, there was not an initialized activity program for each resident.

The facility provided policy for Participation in Activities with revision date of 9/1/11 said residents had the right to attend and participate in activities of their choice. The Director of Therapeutic Recreational Services would maintain a daily record of resident activity involvement.

The facility failed to provide an ongoing individualized activity program in accordance to his/her interests for this cognitively impaired resident.

- The Physician Order Sheet dated 4/29/13 listed the following diagnoses for resident #4007: psychosis (any major mental characterized by a gross impairment in reality testing), senile dementia (a progressive mental disorder characterized by failing memory, confusion), delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue), and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The Annual Minimum Data Set (MDS) 3.0 with the Assessment Reference Date (ARD) of 2/18/13 noted the resident had short and long

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 9	F 248		

term memory problems and was moderately impaired with decision-making skills. Staff noted the resident liked to listen to music, being around pets or animals, doing things in groups, participate in favorite activities and in religious events. He/she needed extensive assistance with all Activities of Daily Living (ADL).

The Care Area Assessment (CAA) for activities did not trigger.

The care plan dated 3/1/13 for impaired cognition listed for staff to engage in conversation with the resident regarding sports, preferring Kansas University (KU).

The care plan for activities with revision date of 6/2/13 noted the resident needed verbal cueing to participate in activities. Interventions included the resident to attend activities on the unit.

The Activity Interest Assessment dated 2/17/13 listed the resident was alert, liked staff to call him/her "Coach", enjoyed sports and watched church on TV. The resident participated in pet therapy, games, music, and TV.

Activity Progress notes dated 5/13/13 (untimed) noted the resident spent a lot of time in the day room, was present for activities and was a passive participant for most. The activity staff to encourage him/her to attend group activities and participate as able.

Review of Weekly Charting dated 3/3/13 noted the resident's activities included visiting with staff and hospice volunteers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 10	F 248		

Review of Weekly Charting dated 5/12/13 noted the resident participated in group activities and 1on 1 with special care staff and hospice volunteers.

Review of the monthly Activity Participation Record for February 2013, March 2013, April 2013, May 2013, and June 2013 revealed the resident an active participant in entertainment/special events, music, current events, sensory stimulation, and TV nearly daily in February, March, and April. He/she was a passive participant in music, TV, and sensory stimulation in May 2013. In June 2013 the resident was an active participant for entertainment, 1 to 1, and watching TV.

An observation on 6/4/13 at 12:45 P.M. hospice staff visited with the resident at the dining room table. Resident was actively engaged in conversation with the staff.

An observation on 6/4/13 at 12:55 P.M. revealed the staff assisted the resident to his/her her room, and laid him/her down for a nap. At 2:35 P.M. volunteers and 3 dogs came in the dayroom for pet therapy, the resident remained in bed during this time.

An observation on 6/5/13 at 10:02 A.M. revealed the resident sat with the other residents in the dining room. The resident did not actively participate in activities. The TV was on and muted, and music played from a compact disc (CD).

An interview on 6/4/13 at 12:22 P.M. with licensed nursing staff J said he/she used the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11	F 248		

bread machine several times a week. It was their aroma therapy for the residents.

An interview on 6/4/13 at 3:35 P.M. with direct care staff S said the resident liked to talk sports, do ball toss, watch TV and visit with staff. He/she said the resident was in bed when the dogs came today but sometimes he/she was awake when they came and the resident enjoyed the dogs.

An interview on 6/5/13 at 1:55 P.M. with direct care staff T said the resident did not participate in activities. He/she said the resident did not pay attention to the TV or even to the music. He/she said they had the TV on and muted with the compact disc (CD) playing music for visual and auditory stimulation.

An interview on 6/5/13 at 2:15 P.M. with direct care staff T said on the secured unit the staff were responsible for doing activities with the residents. He/she said the activities they did daily on the unit depended on what was on the activity calendar. We then mark whether the resident was an active or passive participant on their individual participation record. He/she said we did not use the Activity Intake Assessment or the resident's activity care plan for planning the residents' daily activities.

Interview on 6/5/13 at 2:40 P.M. with administrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the activity program and the activity calendar. He/she said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 12	F 248		

did the care plan for each resident. He/she said he/she did not use the Activity Interest Assessment to figure out the residents' likes and dislikes. He/she said the staff who work on the secured unit do all the activities for the residents residing on the unit. He/she said he/she expected the staff or anyone doing activities to refer to the care plan and gauge the activity program from the care plan.

An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident should have an individualized care plan for activities. He/she acknowledged when staff used only the monthly activity calendar, there was not an initialized activity program for each resident.

The facility provided policy for Participation in Activities with revision date of 9/1/11 said residents had the right to attend and participate in activities of their choice. The Director of Therapeutic Recreational Services would maintain a daily record of resident activity involvement.

The facility failed to provide an ongoing individualized activity program in accordance to his/her interests for this cognitively impaired resident.

- The Physician Order Sheet (POS) dated 4/30/13 listed the following diagnoses for resident #4008: Alzheimers (progressive mental deterioration characterized by confusion and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 13	F 248		

memory failure) and mood disorder.

The Annual Minimum Data Set (MDS) 3.0 with the Assessment Reference Date (ARD) of 1/2/13 listed it was very important for the resident to do favorite activities, participate in religious events, do things with groups of people, listen to music, and be around pets or animals.

The quarterly Minimum Data Set (MDS) 3.0 with Assessment Reference Date (ARD) of 3/20/13 listed the resident had short and long term memory problems and had severely impaired cognition. The resident needed extensive assistance with bed mobility, transfers, personal hygiene, toilet use, and dressing.

The Care Area Assessment (CAA) for cognition dated 1/16/13 noted the resident was alert to self only. He/she was unable to make self understood or understood what others said to him/her. The resident had memory impairments and required supervision with decision making.

The CAA for activities did not trigger.

The CAA for behaviors dated 1/16/13 noted the resident enjoyed sitting in the common area watching TV, listening to the radio, and visiting with other residents.

The care plan dated 6/2/13 for activities noted the resident needed verbal cueing to participate in activities. Interventions listed for the resident to attend activities on and off the unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 14	F 248		

The Weekly Charting note dated 5/29/13 revealed the resident wandered with occasional pacing to and from rooms on the unit. He/she picked up items and carried them with him/her. The resident attended and participated with socialization on the unit, enjoyed music and table games.

The Activity Interest Assessment dated 3/15/13 noted the resident was alert, enjoyed games, music, pets and TV. The resident's spouse visited often and participated in the family meetings.

Activity Progress Note dated 3/15/13 (untimed) said the resident enjoyed visits from his/her spouse. He/she liked to carry a doll, walked all over the unit and participated in activities such as music therapy, ball and pet visits.

Review of the monthly Activity Participation Record dated February 2013, March 2013, April 2013, May 2013 and June 2013 revealed the resident was an active participant in news/current events, exercise, music, watching TV, and sensory activities almost daily. In May 2013, the resident was a passive participant in music and TV watching. In June 2013 revealed he/she was a passive participant in activities.

An observation on 6/4/13 at 12:55 P.M. revealed the resident sat in the day room with the baby doll, talking to it and showing it different items such as the table centerpieces. Music played in the room and the TV was on, and muted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 15	F 248		

Observed the resident on 6/4/13 at 2:31 P.M. holding the doll and watched other residents playing ball toss in the day room. 3 large dogs and 3 volunteers came onto the unit. The resident observed but did not attempt to pet or talk to them.

The resident on 6/4/13 at 2:47 P.M. sat at the table in the day room and watched other residents color.

An observation on 6/5/13 at 10:10 A.M. revealed the resident sat in the day/dining room, watched other residents and talked to no one particular. TV was on and muted while music continued to play.

An interview on 6/4/13 at 3:40 P.M. with direct care staff S said the resident loved the baby doll, played ball, and enjoyed the pets but usually just watched them.

An interview on 6/5/13 at 1:55 P.M. with direct care staff T said the resident loved the doll, walked all over the unit, and talked to staff and other residents. He/she said at times the resident listened when I read to the residents. He/she said the resident did not pay much attention to music or to the TV. He/she said they have the TV on and muted with the compact disc (CD) playing music for visual and auditory stimulation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 16	F 248		

An interview on 6/5/13 at 2:05 P.M. with licensed nursing staff J said the resident liked to carry a doll baby, occasionally enjoyed doing 1on 1 activities with a certain board game, and at times clapped along with the music.

An interview on 6/5/13 at 2:15 P.M. with licensed nursing staff J said on the secured unit the staff were responsible for doing activities with the residents. He/she said what activities they did daily on the unit, depended on what was on the activity calendar. We then mark whether the resident was an active or passive participant on their individual participation record. He/she said we did not use the Activity Intake Assessment or the resident's activity care plan for planning the residents' daily activities.

Interview on 6/5/13 at 2:40 P.M. with administrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the activity program and the activity calendar. He/she said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then did the care plan for each resident. He/she said he/she did not use the Activity Interest Assessment to figure out the residents' likes and dislikes. He/she said the staff who work on the secured unit do all the activities for the residents residing on the unit. He/she said he/she expected the staff or anyone doing activities to refer to the care plan and gauge the activity program from the care plan.

An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 17 should have an individualized care plan for activities. He/she acknowledged when staff used only the monthly activity calendar, there was not an initialized activity program for each resident. The facility provided policy for Participation in Activities with revision date of 9/1/11 said residents had the right to attend and participate in activities of their choice. The Director of Therapeutic Recreational Services would maintain a daily record of resident activity involvement. The facility failed to provide an ongoing individualized activity program in accordance to his/her interests for this cognitively impaired resident.	F 248		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 18	F 279		

§483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 49 residents. The sample included 9 residents. Based on observation, record review and interview the facility failed to develop an individualized plan of care for activities for 4 (#4001, #4006, #4007, #4008) of the 4 residents reviewed for activities.

Findings included:

- The Physician Order Sheet (POS) dated 5/30/13 listed the following diagnoses for resident #4001: agitation (extreme emotional disturbance) and dementia (progressive mental disorder characterized by failing memory, confusion).

The admission Minimum Data Set 3.0 with the Assessment Reference Date (ARD) 5/10/13 noted the resident had short and long term memory problems and was moderately impaired with decision-making skills. It was important for him/her to listen to music, do things in groups of people, go outside when the weather was nice and was somewhat important for him/her to participate in religious events, do favorite activities, keep up with the news, and be around pets or animals. The resident required staff supervision to being independent with all Activities of Daily Living (ADL) except needed extensive assistance with personal hygiene.

The Care Area Assessment (CAA) for Cognition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19	F 279		

dated 5/14/13 noted the resident was not sure that he/she was in a nursing home, was unable to report the season or the year, and had difficulty responding to questions as he/she spoke of things irrelevant to the questions asked by staff.

The ADL CAA dated 5/14/13 listed the resident was admitted from another facility. He/she was mostly independent with mobility and transfers, but required some occasional physical assistance.

Care plan dated 5/21/13 for impaired cognition listed interventions to maintain a calm and relaxed manner, speak slowly and distinctly, introduce self frequently, provide visual cues, use simple direct request, reorientation/validation as needed, provide consistency in the daily routine, face the resident when speaking and encourage use of visual cues in room.

The clinical record lacked a care plan for activities.

Activity Interest Assessment dated 5/13/13 listed the resident was alert to name and had short and long term memory problems. He/she enjoyed games, music, exercise, reading, food, pets , gardening, and watching TV. News and religion were noted as past interests. He/she interacted well with spouse. Staff to encourage group activities and assist as the resident was able.

Observation on 6/4/13 at 11:50 A.M. revealed the resident laid in bed, watching TV.

On 6/5/13 at 7:50 A.M. there was a crossword puzzle book and Bible laying on the bedside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20	F 279		

table. The resident said he/she did not read the Bible, they had them in all the rooms. He/she said he enjoyed doing crossword puzzles.

Observation on 6/5/13 at 10:30 A.M. revealed the resident attended the religious events activity.

Observation revealed residents attended the Bingo activity on 6/5/13 at 3:00 P.M. but the resident remained in his/her room, door closed, room dark, TV on, eyes closed. Conversation with the resident at 3:30 P.M., revealed he/she enjoyed Bingo but he/she did not remember anyone asking him/her to go to Bingo today.

An interview on 6/5/13 at 11:20 A.M. consultant HH said the facility would start doing activity care plans on everyone and not just those that the MDS triggered. He/she said the facility would make the care plans individualized to reflect residents likes and dislikes.

An interview on 6/5/13 at 1:45 P.M. with direct care staff Q said the resident on the day shift consisted of going to Bingo or going to the unit and visiting with his/her spouse. He/she said otherwise the resident stayed in his/her room and watched TV or napped.

Interview on 6/5/13 at 2:40 P.M. an interview with administrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the activity program and the activity calendar. He/she said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then did the care plan for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21	F 279		

Administrative staff C said he/she did not use the Activity Interest Assessment to figure out the residents likes and dislikes. He/she acknowledged there was not an activity care plan for this resident. .

An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident should have an individualized care plan for activities.

An interview on 6/5/13 at 4:45 P.M. with direct care staff R said the resident occasionally visited with his/her spouse in the afternoon but usually stayed in his/her room and watched TV in the evening.

The facility provided policy for Care Plan with revision date of 9/1/11 said an "interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis". The procedure stated "there may be additional problem areas not triggered by the MDS, which will need to be addressed in the Care Plan. All direct care staff must always know, understand and follow their Resident's Care Plan".

The facility failed to develop and individualized activity care plan for this cognitively impaired resident ongoing individualized activity program in accordance to his/her interests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 22	F 279		

- The Physician Order Sheet (POS) dated 4/29/13 listed the following diagnoses for resident #4006: dementia (progressive mental disorder characterized by failing memory, confusion), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind).

The annual Minimum Data Set (MDS) 3.0 with the Assessment Reference Date (ARD) of 3/15/13 listed the resident had short and long term memory problems and was severely impaired with decision making skills. The resident liked listening to music and doing things in groups. He/she needed extensive assistance with bed mobility, transfers, dressing, eating, personal hygiene, and limited assistance with walking on the unit and in the corridor.

The Activity Care Area Assessment (CAA) dated 3/18/13 noted the resident triggered the CAA because he/she did little in activities. He/she attended activities but was mostly a passive observer.

The care plan for activities dated 6/2/13 noted the resident needed verbal cueing to participate. Interventions included the resident to attend activities on and off the unit.

The Activity Interest Assessment dated 3/15/13 noted the resident was alert with short and long term memory loss, was non-verbal, liked games, music, exercise, pets and TV. He/she needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 23	F 279		

encouragement to attend activities and enjoyed sitting in the day room, watching TV.

Review of Activity Progress notes dated 3/15/13 said the resident enjoyed sitting in the dayroom participating in music therapy, pet visits, and some exercise. He/she enjoyed independent activities such as watching TV and observing people around him/her.

Observation on 6/4/13 at 12:35 P.M. revealed the resident sat on the couch in the day room with his/her head down and eyes open. The TV was on but muted while a compact disc (CD) played blue grass music.

An observation on 6/4/13 at 2:10 P.M. revealed the staff assisted the resident to his/her her room, and laid him/her down for a nap. At 2:35 P.M. volunteers and 3 dogs came in the dayroom for pet therapy, the resident remained in bed during this time.

An observation on 6/5/13 at 10:15 A.M. revealed the resident sat on the couch in the dayroom, had his/her head down, eyes closed and rested quietly. Music on in the day room, TV on and muted.

An interview on 6/4/13 at 3:35 P.M. with direct care staff S said the resident would join in activities sometimes but usually watched. He/she seemed to enjoy music and ball toss.

An interview on 6/5/13 at 11:20 A.M. interview with consultant HH said the facility would start doing activity care plans on everyone and not just those that the MDS triggered. He/she said the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 24	F 279		

facility would make the care plans individualized to reflect residents' likes and dislikes.

An interview on 6/5/13 at 1:55 P.M. with direct care staff T said the resident occasionally participated in ball toss but not too often. He/she said the resident liked music but did not like staff reading to him/her and did not like to watch TV. Staff said the TV was on mute and the music going so the residents had both visual and auditory stimulation. He/she said pet therapy must be later in the day because he/she never saw pets on the unit during the day shift. He/she said the resident laid down every afternoon for a nap.

An interview on 6/5/13 at 2:03 P.M. with licensed nursing staff J said there was one game the resident would occasionally play with him/her on a 1 to 1 or would sometimes participate in group activities with staff assistance.

An interview on 6/5/13 at 2:15 P.M. with licensed nursing staff J said on the secured unit the staff were responsible for doing activities with the residents. He/she said what activities they did daily on the unit depended on what was on the activity calendar. We then mark whether the resident was an active or passive participant on their individual participation record. He/she said we did not use the Activity Intake Assessment or the resident's activity care plan for planning the residents' daily activities.

On 6/5/13 at 2:40 P.M. an interview with adminstrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 25	F 279		

activity program and the activity calendar. He/she said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then did the care plan for each resident. He/she said he/she did not use the Activity Interest Assessment to figure out the residents likes and dislikes. He/she said the staff who work on the secured unit did all the activities for the residents residing on the unit. He/she said he/she expected the staff or anyone doing activities to refer to the care plan and gauge the activity program from the care plan.

An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident should have an individualized care plan for activities. He/she acknowledged that when staff used only the monthly activity calendar, there was not an initialized activity program for each resident.

The facility provided policy for Care Plan with revision date of 9/1/11 said an "interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis". The procedure stated "there may be additional problem areas not triggered by the MDS, which will need to be addressed in the Care Plan. All direct care staff must always know, understand and follow their Resident's Care Plan".

The facility failed to develop and individualized activity care plan for this cognitively impaired resident ongoing individualized activity program in accordance to his/her interests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 26	F 279		

- The Physician Order Sheet dated 4/29/13 listed the following diagnoses for resident #4007: psychosis (any major mental characterized by a gross impairment in reality testing), senile dementia (a progressive mental disorder characterized by failing memory, confusion), delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue), and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The Annual Minimum Data Set (MDS) 3.0 with the Assessment Reference Date (ARD) of 2/18/13 noted the resident had short and long term memory problems and was moderately impaired with decision-making skills. Staff noted the resident liked to listen to music, being around pets or animals, doing things in groups, participate in favorite activities and in religious events. He/she needed extensive assistance with all Activities of Daily Living (ADL).

The Care Area Assessment (CAA) for activities did not trigger.

The care plan dated 3/1/13 for impaired cognition listed for staff to engage in conversation with the resident regarding sports, preferring Kansas University (KU).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 27	F 279		

The care plan for activities with revision date of 6/2/13 noted the resident needed verbal cueing to participate in activities. Interventions included for the resident to attend activities on the unit.

The Activity Interest Assessment dated 2/17/13 listed the resident was alert, liked staff to call him/her "Coach", enjoyed sports and watched church on TV. The resident participated in pet therapy, games, music, and TV.

Activity Progress notes dated 5/13/13 (untimed) noted the resident spent a lot of time in the day room, was present for activities and was a passive participant for most. The activity staff to encourage him/her to attend group activities and participate as able.

Review of Weekly Charting dated 3/3/13 noted the resident's activities included visiting with staff and hospice volunteers.

Review of Weekly Charting dated 5/12/13 noted the resident participated in group activities and 1on 1 with special care staff and hospice volunteers.

An observation on 6/4/13 at 12:45 P.M. hospice staff visited with the resident at the dining room table. Resident was actively engaged in conversation with the staff.

An observation on 6/4/13 at 12:55 P.M. revealed the staff assisted the resident to his/her her room, and laid him/her down for a nap. At 2:35 P.M. volunteers and 3 dogs came in the dayroom for pet therapy, the resident remained in bed during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 28	F 279		

this time.

An observation on 6/5/13 at 10:02 A.M. revealed the resident sat with the other residents in the dining room. The resident did not actively participate in activities. The TV was on and muted, and music played from a compact disc (CD).

An interview on 6/4/13 at 12:22 P.M. with licensed nursing staff J said he/she used the bread machine several times a week. It was their aroma therapy for the residents.

An interview on 6/4/13 at 3:35 P.M. with direct care staff S said the resident liked to talk sports, do ball toss, watch TV and visit with staff. He/she said the resident was in bed when the dogs came today but sometimes he/she was awake when they came and the resident enjoyed the dogs.

An interview on 6/5/13 at 11:20 A.M. consultant HH said the facility would start doing activity care plans on everyone and not just those that the MDS triggered. He/she said the facility would make the care plans individualized to reflect residents' likes and dislikes.

An interview on 6/5/13 at 1:55 P.M. with direct care staff T said the resident did not participate in activities. He/she said the resident did not pay attention to the TV or even to the music. He/she said they had the TV on and muted with the compact disc (CD) playing music for visual and auditory stimulation.

An interview on 6/5/13 at 2:15 P.M. with direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 29	F 279		

care staff T said on the secured unit the staff were responsible for doing activities with the residents. He/she said what activities they did daily on the unit depended on what was on the activity calendar. We then mark whether the resident was an active or passive participant on their individual participation record. He/she said we did not use the Activity Intake Assessment or the resident's activity care plan for planning the residents' daily activities.

Interview on 6/5/13 at 2:40 P.M. with administrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the activity program and the activity calendar. He/she said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then did the care plan for each resident. He/she said he/she did not use the Activity Interest Assessment to figure out the residents' likes and dislikes. He/she said the staff who worked on the secured unit did all the activities for the residents' residing on the unit. He/she said he/she expected the staff or anyone doing activities to refer to the care plan and gauge the activity program from the care plan.

An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident should have an individualized care plan for activities. He/she acknowledged that when staff used only the monthly activity calendar, there was not an initialized activity program for each resident.

The facility provided policy for Care Plan with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 30	F 279		

revision date of 9/1/11 said an "interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis". The procedure stated "there may be additional problem areas not triggered by the MDS, which will need to be addressed in the Care Plan. All direct care staff must always know, understand and follow their Resident's Care Plan".

The facility failed to develop and individualized activity care plan for this cognitively impaired resident ongoing individualized activity program in accordance to his/her interests.

- The Physician Order Sheet (POS) dated 4/30/13 listed the following diagnoses for resident #4008: Alzheimers (progressive mental deterioration characterized by confusion and memory failure) and mood disorder.

The Annual Minimum Data Set (MDS) 3.0 with the Assessment Reference Date (ARD) of 1/2/13 listed it was very important for the resident to do favorite activities, participate in religious events, do things with groups of people, listen to music, and be around pets or animals.

The quarterly Minimum Data Set (MDS) 3.0 with Assessment Reference Date (ARD) of 3/20/13 listed the resident had short and long term memory problems and had severely impaired cognition. The resident needed extensive assistance with bed mobility, transfers, personal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

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F 279	Continued From page 31	F 279		

hygiene, toilet use, and dressing.

The Care Area Assessment (CAA) for cognition dated 1/16/13 noted the resident was alert to self only. He/she was unable to make self understood or understood what others said to him/her. The resident had memory impairments and required supervision with decision making.

The CAA for activities did not trigger.

The CAA for behaviors dated 1/16/13 noted the resident enjoyed sitting in the common area watching TV, listening to the radio, and visiting with other residents.

The care plan dated 6/2/13 for activities noted the resident needed verbal cueing to participate in activities. Interventions listed for the resident to attend activities on and off the unit.

The Weekly Charting note dated 5/29/13 revealed the resident wandered with occasional pacing to and from rooms on the unit. He/she picked up items and carried them with him/her. The resident attended and participated with socialization on the unit, enjoyed music and table games.

The Activity Interest Assessment dated 3/15/13 noted the resident was alert, enjoyed games, music, pets and TV. The resident's spouse visited often and participated in the family meetings.

Activity Progress Note dated 3/15/13 (untimed) said the resident enjoyed visits from his/her spouse. He/she liked to carry a doll, walked all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 32	F 279		

over the unit and participated in activities such as music therapy, ball and pet visits.

An observation on 6/4/13 at 12:55 P.M. revealed the resident sat in the day room with the baby doll, talking to it and showing it different items such as the table centerpieces. Music played in the room and the TV was on, and muted.

Observed the resident on 6/4/13 at 2:31 P.M. holding the doll and watched other residents playing ball toss in the day room. 3 large dogs and 3 volunteers came onto the unit. The resident observed but did not attempt to pet or talk to them.

The resident on 6/4/13 at 2:47 P.M. sAT at the table in the day room and watched other residents color.

An observation on 6/5/13 at 10:10 A.M. revealed the resident sat in the day/dining room, watched other resident and talked to no one particular. TV was on and muted while music continued to play.

An interview on 6/4/13 at 3:40 P.M. with direct care staff S said the resident loved the baby doll, played ball, enjoyed the pets but usually just watched them.

An interview on 6/5/13 at 11:20 A.M. interview with consultant HH said the facility would start doing activity care plans on everyone and not just those that the MDS triggered. He/she said the facility would make the care plans individualized to reflect residents likes and dislikes.

An interview on 6/5/13 at 1:55 P.M. with direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 33	F 279		

care staff T said the resident loved the doll, and walked all over the unit, talked to staff and other residents. He/she said at times the resident listened when I read to the residents. He/she said the resident did not pay much attention to music or to the TV. He/she said they have the TV on and muted with the compact disc (CD) playing music for visual and auditory stimulation.

An interview on 6/5/13 at 2:05 P.M. with licensed nursing staff J said the resident liked to carry a doll baby, occasionally enjoyed doing 1 on 1 activities with a certain board game, and at times clapped along with the music.

An interview on 6/5/13 at 2:15 P.M. with licensed nursing staff J said on the secured unit the staff were responsible for doing activities with the residents. He/she said what activities they did daily on the unit depended on what was on the activity calendar. We then mark whether the resident was an active or passive participant on their individual participation record. He/she said we did not use the Activity Intake Assessment or the resident's activity care plan for planning the residents' daily activities.

Interview on 6/5/13at 2:40 P.M. an interview with administrative staff C said when the facility first admitted a resident, he/she visited with the new resident on the second day and explained the activity program and the activity calendar. He/she said he/she completed the activity assessment portion of the MDS by the fifth day and then made a progress note regarding the resident and then did the care plan for each resident. He/she said he/she did not use the Activity Interest Assessment to figure out the residents likes and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 34 dislikes. He/she said the staff who work on the secured unit did all the activities for the residents residing on the unit. He/she said he/she expected the staff or anyone doing activities to refer to the care plan and gauge the activity program from the care plan. An interview on 6/5/13 at 2:50 P.M. with administrative nursing staff D said each resident should have an individualized care plan for activities. He/she acknowledged when staff used only the monthly activity calendar, there was not an initialized activity program for each resident. The facility provided policy for Care Plan with revision date of 9/1/11 said an "interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis". The procedure stated "there may be additional problem areas not triggered by the MDS, which will need to be addressed in the Care Plan. All direct care staff must always know, understand and follow their Resident's Care Plan". The facility failed to develop and individualized activity care plan for this cognitively impaired residentongoing individualized activity program in accordance to his/her interests.	F 279		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35	F 314		

they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 49 residents. The sample included 9 residents. Based on observation, interview, and record review the facility failed to prevent the development of 1 stage II pressure ulcer and 1 unstageable pressure ulcer for 1 (#4002) of 3 residents reviewed for pressure ulcers.

Findings included:

- Resident #4002's admission Minimum Data Set 3.0 (MDS) dated 3-7-13 documented the resident's Brief Interview for Mental Status score of 14 which indicated the resident was cognitively intact. The resident required extensive assistance of 1 staff with bed mobility, transfers, toileting and personal hygiene. The resident did not have pressure ulcers.

The 3-7-13 Care Area Assessment (CAA) for Activities of Daily Living (ADLs) documented the resident was able to ambulate with a rolling walker as recent as 2-20-13, but was chair bound now.

The 3-7-13 Incontinence CAA documented the resident required extensive assistance with toileting, had incontinence, and a recent urinary tract infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 36	F 314		

The 3-7-13 Pressure Ulcer CAA documented the resident with a Braden Score (an assessment to determine a resident ' s risk for development of pressure ulcers) of 17 which indicated the resident was at risk for development of pressure ulcers, and preventive measures were in place to protect the resident's skin.

The 3-7-13 dietician note documented the resident received a regular diet, had good intake of food, the resident's albumin (a test to determine the amount of protein in the blood) was low at 2.3 grams per deciliter (g/dl). The normal range was 3.5 - 5.7 g/dl. The resident ' s total protein was low at 4.8 g/dl and the normal range was 6.4 - 8.9 g/dl. The dietician recommended the resident received protein snacks two times daily, protein supplement 30 milliliters (ml) three times daily, encouragement of increased fluid intake and increased protein.

The 2-28-13 Admission Care Plan directed staff to reposition the resident every 2 hours, required assistance of 1 staff with bed mobility, 2 staff with toileting, had pneumonia (inflammation of the lungs) and received an intravenous (IV) antibiotic.

The 3-11-13 care plan identified the resident was at risk nutritionally related to a low Albumin level and interventions included; monitoring intake and diet compliance, honor food preferences, honor requests for food, encourage fluids, the resident liked to sleep late, so offer snacks upon arising, the resident preferred small meals plus snacks due to history of a gastric bypass (surgical procedure involving the stomach and small intestine for the purpose of weight loss), preferred to eat in his/her room, provide nutritional/wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 37	F 314		

supplements as ordered, protein supplement daily as ordered and dietician visits as needed.

The care plan lacked specific dates the interventions were implemented.

The 3-11-13 care plan documented the resident with the potential for further skin breakdown related to immobility due to weakness, incontinence of bowel and bladder and declined requests or encouragement to reposition. The resident refused to elevate his/her lower extremities. Undated interventions included a nutritional assessment upon readmission and quarterly, offer and encourage fluids often throughout the day to promote hydration, assess for changes in cognition status, weekly skin checks and/or with daily cares and report and document any changes in skin color and turgor to the nurse, and encourage the resident to turn and reposition often while in bed and while sitting in the wheelchair to promote circulation and comfort. The care plan also documented the resident with a pressure reducing cushion in the wheelchair to relieve pressure and promote comfort.

The care plan lacked specific dates the interventions were implemented.

Record review of the 3-19-13 nurse's note at 1:45 P.M. documented the resident with an open area to the resident ' s left buttock that measured 0.5 centimeters (cm) circumference. The facility obtained an order for Calazime cream (a skin protectant cream), and placed a pressure reducing cushion in the resident's wheelchair. This contradicted the 3/13/13 care plan which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 38	F 314		

said the resident had a wheel chair cushion.

Record review of the 3-22-13 nurse's note times 11:45 A.M. documented the resident complained of heel pain and staff noted a 4 cm by (x) 2.5 cm dark colored blister on the resident ' s right heel. Staff notified the physician and received an order for skin prep (a skin protectant that reduced friction) to the blister on the right heel two times daily, place a pillow under the resident ' s calves while in bed, and place the right foot in a Prafo (a specialized boot that reduced pressure on the heels) boot at all times.

The 3-22-13 care plan documented the resident with a right heel ulcer and redness on the left heel. Interventions included treatment as ordered, a low air loss mattress to promote circulation and comfort, encourage the resident to elevate his/her lower extremities, provide pressure relieving devices on both heels as ordered to decrease pressure and seen weekly by the wound clinic for treatment and review.

Record review of the 3-25-13 nurse's note 6:30 A.M. documented the physician ordered additional lab due to the resident's increased confusion.

Record review of the 3-25-13 nurse's note with no time written documented on 3-22-13 at 3:30 P.M. the resident had swelling of the lower legs. The right heel blister was purple in color and requested a Doppler study (a test to determine arterial blood flow in the lower extremities).

The Ultrasound Report dated 3/28/13following a venous study revealed normal flow and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 39	F 314		

compressibility from the bilateral common femoral veins (blood vessels located near the thigh or bone or femur) through the bilateral popliteal veins (blood vessels located behind the knee) in the calves and the impression documented no evidence of deep venous thrombosis (blood clot) in the bilateral lower extremities.

Record review of the 3-29-13 nurse's note documented clarification for an order for Physical therapy 2-3 times weekly for 4 weeks, and a therapy assessment for use of mobility rails on the resident's bed to increase the resident's participation with transfers.

On 4-2-13 the resident completed IV antibiotic therapy.

Nurse's notes dated 4-16-13 at 11:30 A.M. documented the resident with 2 plus pitting edema (a slight indentation of the tissue due to excess fluid accummulation) in both lower extremities and the physician looked at the resident's right heel.

The 4-17-13 nurse's note timed 9:45 A.M. documented the area on the resident's right heel opened and staff notified the physician and received an order for Duoderm (a specialized dressing used for treatment of pressure ulcers) dressing.

The 4-24-13 nurse's note timed 12:45 P.M. documented the resident left the facility and went to the wound clinic.

The 4-24-13 Wound Clinic note documented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 40	F 314		

resident had black eschar (dead tissue) on the right heel. The physician debrided the wound and documented the resident with positive pulses in all four extremities and displayed venous insufficiency (abnormal blood flow through veins) with edema of the lower extremities. The physician documented his/her findings as a pressure ulcer on the right heel.

The X-ray report of the resident's right foot dated 4/25/13 documented the resident with swelling and the radiologist did not observe a fracture or osteomyelitis (infection of the bone).

Record review on 5-9-13 at 10:00 P.M. revealed the resident started on Lasix (a diuretic medication to expel fluid from the body) 20 milligrams (mg) daily for 3 days.

Nurse's note dated 5-10-13 and timed 5:50 A.M. documented the resident went to the emergency department at 8:43 P.M.

Observation on 6-4-13 at 11:55 A.M. revealed the resident in his/her bed. Staff brought the resident a room tray for lunch and the resident ate independently.

Observation on 6-4-13 at 3:53 P.M. revealed the resident laid on his/her back with the head of his/her bed elevated approximately 30 degrees. The resident leaned forward and repositioned his/her pillow and watched TV.

Observation on 6-4-13 at 4:14 P.M. revealed the resident in bed with his/her upper body positioned slightly toward the left side and watched TV.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 41 Observation on 6-5-13 at 8:32 A.M. revealed the ambulance at the resident's room door to transfer the resident to the hospital. During an interview on 6-5-13 at 7:27 A.M. the resident stated he/she had a sore on his/her heel and it covered the "whole" heel. The resident said he/she wore special boots and had to keep them on all the time. The resident stated he/she was not able to reposition him/herself in bed independently and needed the help of staff. The resident said his/her legs hurt most of the time. During staff interview on 6-5-13 at 9:47 A.M. administrative staff D stated the resident had pain and the physician sent the resident to the hospital. During staff interview on 6-5-13 at 1:49 P.M. direct care staff O stated the resident was able to "scoot" his/her hips and turn from side to side but was not able to stay on his/her side without a support pillow to hold him/her in position. Direct care staff stated they kept the resident's heels off the bed and he/she did not refuse to do it. He/she stated sometimes the resident became upset and refused care, but if staff left the room and came back 5 minutes later, the resident was cooperative. Direct care staff O stated he/she repositioned the resident every hour and the resident did refuse yesterday because of leg pain. On 6-5-13 at 2:14 P.M. licensed nurse H stated the resident developed an open area on his/her left buttock on March 19th, 2013 and staff repositioned the resident every 2 hours. He/she stated the resident was able to state his/her needs and notified staff with toileting needs.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E641	A. BUILDING _____ B. WING _____	C 06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 42	F 314		

He/she stated the resident had confusion at times such as not remembering staff was in the room or if he/she received medications. Licensed nurse H stated the resident was not able to get out of bed on his/her own and required assistance of staff for positioning and liked to stay in bed. He/she stated the pressure ulcer on the buttocks healed on 4-5-13. Licensed nurse H also stated the resident had a blister on his/her right heel and wore a Prafo boot after they found the wound.

During staff interview on 6-5-13 at 2:42 P.M. licensed staff I stated that prior to development of the pressure ulcers, staff repositioned the resident every 2 hours, the resident was continent of bowel and bladder, and able to state his/her needs. After the development of the pressure ulcers, the resident now received skin prep for his/her heels, had Prafo boots or a pillow under the calves and required assistance of staff for positioning in bed.

On 6-5-13 at 2:55 P.M. direct care staff P stated the resident was repositioned every hour, able to state his/her needs, and was not able to reposition his/her self without assistance of staff.

The facility provided 9-1-11 Pressure Ulcer Policy and Procedure documented if a resident entered the facility without pressure sores, he/she did not develop pressure sores unless the resident ' s clinical condition demonstrated they were unavoidable.

The facility failed to prevent the development of an avoidable stage II pressure ulcer and an unstageable pressure ulcer for this resident who required extensive staff assistance with ADLs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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